

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

6722-62-024709
STATE FILE NUMBERDO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318
FILED JUL 12 1962

Primary Registration District No.

1003

Registrar's No.

VS 300
Rev. 4/59

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USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN St. Louis	
Length of stay in 1b 83 yrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4070 Alma Avenue		d. STREET ADDRESS (If outside, give location) 4070 Alma Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM CHARLES (CARL) HARTMANN		4. DATE OF DEATH Month Day Year July 5, 1962	
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/13/1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) buyer and salesman		10b. KIND OF BUSINESS OR INDUSTRY produce	9. AGE (last birthday) 83
11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Henry Hartmann		13b. MOTHER'S MAIDEN NAME Elizabeth Horst	
14. NAME OF HUSBAND OR WIFE Ida Roesch		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. INFORMANT Mrs. Ida Hartmann, 4070 Alma Avenue		17. ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Apoplexy Generalized arteriosclerosis 334X Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Three previous cerebral hemorrhages		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Jan 1957, to July 5, 1962 and last saw him alive on June 30, 1962 Death occurred at 6:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE Albert J. Gnade M.D. (Degree or title)	
22b. ADDRESS 3606 GRAVOIS		22c. DATE SIGNED 7-6-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 7/9/62	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
24. FUNERAL DIRECTOR BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave.		25. DATE RECD. BY LOCAL REG. JUL 8 1962	
26. REGISTRAR'S SIGNATURE Earl Smith, M.D.			

Mr. Albert Gnade
3606 Urvovis Ave.
1-4 PM

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

[Handwritten Signature]

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.